National Outcome Measures (NOMs) for Children and Families

April 2006

Overview

The mission of the Substance Abuse and Mental Health Services Administration (SAMHSA) is to build resilience and facilitate recovery for people with or at risk for substance use and/or mental disorders. In 2001, SAMHSA created a matrix management system that outlines and guides the agency's activities in pursuit of this mission. The matrix includes 11 program priority areas, one of which addresses the unique needs of children and families with or at risk for mental and/or substance use disorders. The matrix also includes a set of cross-cutting principles, including one recognizing the critical need for data for performance measurement and management. SAMHSA is in the process of developing and implementing a data strategy in order to measure the agency's success in meeting its mission. The National Outcome Measures (NOMs) is a key component of the data strategy. The NOMs have introduced a set of 10 measurable outcomes for three key areas: mental health services, substance abuse treatment, and substance abuse prevention. As part of this effort, SAMHSA's activities and data have been reviewed to determine what outcomes could be measured for each NOMs domain.

The highlights contained here represent the best summary information about NOMs currently available from national-level SAMHSA data sets for the children and families program priority area. Since this is a preliminary overview, these national-level data are used to describe possible baselines or starting points from which to measure changes in the future. These baseline data on children and families are available for 7 of the 10 NOMs domains: Reduced Morbidity, Employment, Stability in Housing, Access/Capacity, Retention, Social Connectedness, and Perception of Care. Further work is under way to identify potential data sources for use as measures of outcomes for the remaining domains. While not the focus of this summary, it is equally important to mention that SAMHSA's grant programs have demonstrated success and effectiveness in improving the lives of children and families throughout the country. SAMHSA initiatives have reduced alcohol and other drug use, improved emotional and behavioral functioning, increased attendance and performance at school, and reduced law enforcement contacts.

SAMHSA's Action Plan for the children and families program priority area is available at http://www.samhsa.gov/Matrix/SAP_children.aspx.

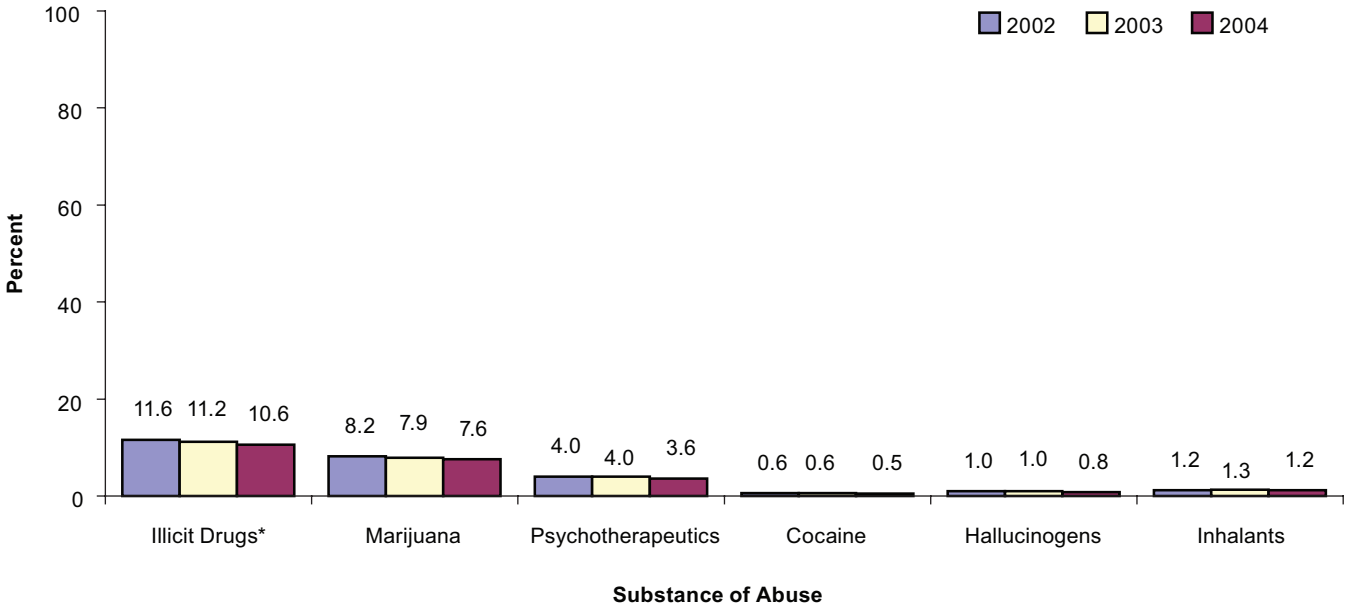
National Outcome Measures Overview

SAMHSA has developed these 10 NOMs domains in collaboration with the States. These domains are designed to embody meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in their communities. The development and application of NOMs is a key component of the SAMHSA initiative to set performance targets for State and Federally funded initiatives and programs for substance abuse prevention and mental health promotion, early intervention, and treatment services. The NOMs domains and their associated outcome measures are as follows:

- Reduced Morbidity (for substance abuse—decreased use of substances of abuse, nonuser stability, increasing perceived risk, increasing disapproval, increasing age of first use; for mental health—decreased mental illness symptomatology)
- Employment/Education (getting and keeping a job; workplace drug and alcohol policy; alcohol, tobacco, and other drug school suspensions and expulsions; or enrolling and staying in school)
- Crime and Criminal Justice (decreased criminality, incarcerations, and alcohol-related car crashes and injuries)
- Stability in Housing (increased stability in housing)
- Social Connectedness (family communication about drug use, increasing social supports and social connectedness)
- Access/Capacity (increased access to services/increased service capacity)
- Retention (for substance abuse—increased retention in treatment, access to prevention messages, evidence based programs/strategies; for mental health—reduced utilization of psychiatric inpatient beds)
- Perception of Care (or services)
- Cost Effectiveness
- Use of Evidence-Based Practices

Current data regarding substance abuse among the children and families population are available from several of SAMHSA's national-level data sets, including the

Figure 1. Percent of Adolescents (Aged 12–17) Reporting Past Month Use of Selected Illicit Drugs: 2002, 2003, and 2004



* Difference between the 2002 estimate and the 2004 estimate significant at 0.05 level. See notes at end.
Source: SAMHSA, OAS, (2005), Results from the 2004 National Survey on Drug Use and Health: National findings [Figure 2.4].

National Survey on Drug Use and Health (NSDUH), the National Survey of Substance Abuse Treatment Services (N-SSATS), the Treatment Episode Data Set (TEDS), and the Uniform Reporting System (URS). However, it must be noted that TEDS data are primarily drawn from substance abuse treatment facilities that receive some public funding. In addition, URS, which is the major source of mental health reporting for SAMHSA's Center for Mental Health Services (CMHS), consists of data collected voluntarily by the States. These data tend to have large ranges in the values reported because of important variations in State data systems, reporting capacity, means of instrumentation, data collection methods, and variable definitions, as well as in the number of States reporting any data for a specific variable. Finally, the URS data set represents only individuals who have been seen through a publicly funded mental health system served by the State Mental Health Authority. The URS data set does not include individuals seen by private providers or individuals receiving their mental health services from other agencies such as the criminal and juvenile justice systems, homeless programs, and child welfare. However, CMHS is working with an external expert panel to develop a plan to refine its data and expand its data sets.

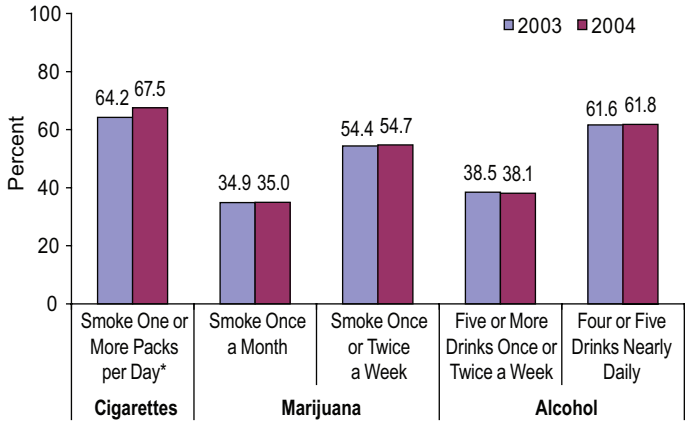
Recognizing that there are challenges to critically examining the NOMs in the children and families program priority area, SAMHSA is striving to develop more in-depth and comprehensive data (e.g., detailed age intervals particularly for children younger than 12, child-parent relational data, and complete/consistent data for all States) and to fine-tune strategies to effectively collect data on children. SAMHSA is also making continuous efforts to elaborate the definitions of the outcomes. As SAMHSA refines and implements the data strategy for performance measurement and management, additional NOMs data for children and families will be developed.

Substance Abuse Prevention NOMs for Children and Families

Within the substance abuse prevention area, NOMs for children and families are available from SAMHSA's national-level data sets under the domains of Abstinence from Drug/Alcohol Use, Retention, Social Connectedness, and Employment. Much of these data come from NSDUH.[1, 2, 3]

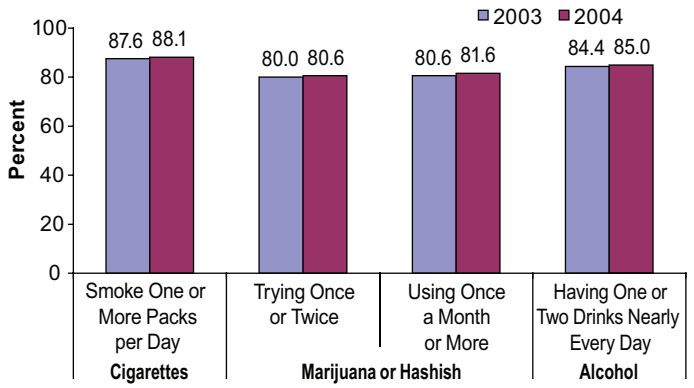
Under the Abstinence from Drug/Alcohol Use domain, data are available for the following measures: 30-day substance use, perceived risk/harm of use, perception of disapproval/attitude, and age of first use. The steady decline in past month usage over a three-year period shows that national efforts are having an impact across the board in reducing 30-day use of multiple kinds of drugs (Figure 1). Figure 2 documents the desired effect of increasing adolescents' perception of great risk of harm. For measures of cigarette, marijuana, and alcohol use, perceptions of great risk of harm increased from 2003 to 2004 in all cases, except for having five or more drinks of alcohol once or twice a week. Similarly, Figure 3 shows a general increase in adolescents' disapproval of peers using cigarettes, marijuana, and

Figure 2. Percent of Adolescents (Aged 12–17) Perceiving Great Risk of Harm from Use of Cigarettes, Marijuana, and Alcohol: 2003 and 2004



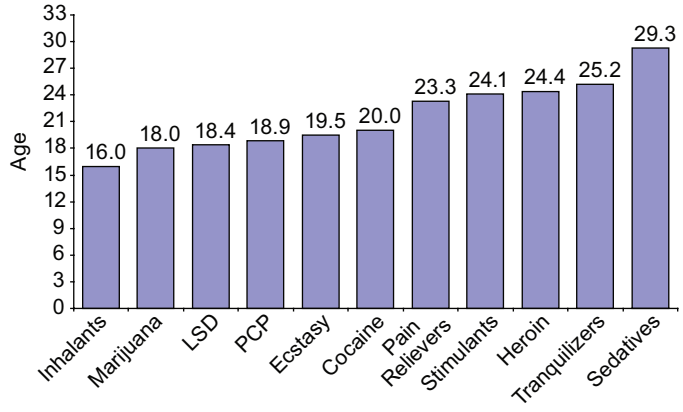
* Difference between the 2003 estimate and the 2004 estimate is statistically significant at the 0.05 level. See notes at end.
Source: SAMHSA, OAS, (2005), 2004 National Survey on Drug Use and Health: Detailed tables [Table 3.1B].

Figure 3. Percent of Adolescents (Aged 12–17) Feeling Strong/Somewhat Disapproval about Peers Using or Trying Cigarettes, Marijuana or Hashish, and Alcohol: 2003 and 2004



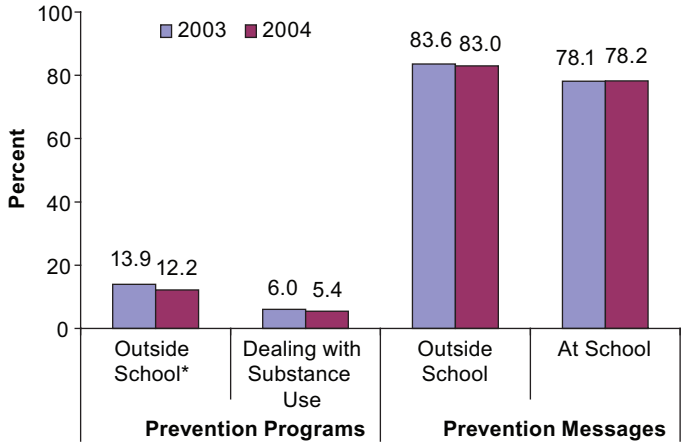
See notes at end.
Source: SAMHSA, OAS, (2005), 2004 National Survey on Drug Use and Health: Detailed tables [Tables 3.30B, 3.31B, 3.32B, 3.33B].

Figure 4. Mean Age for Past Year Initiates, by Illicit Drug: 2004



Source: SAMHSA, OAS, (2005), Results from the 2004 National Survey on Drug Use and Health: National findings [Figure 5.3].

Figure 5. Percent of Adolescents (Aged 12–17) Who Participated in Prevention Programs or Were Exposed to Prevention Messages in Past Year: 2003 and 2004



* Difference between the 2003 estimate and the 2004 estimate is statistically significant at the 0.01 level. See notes at end.
Source: SAMHSA, OAS, (2005), 2004 National Survey on Drug Use and Health: Detailed tables [Tables 3.36B, 3.37B, 3.40B, 3.41B].

alcohol. Figure 4 represents baseline data on the mean age of first use among past year initiates for a number of substances. Other available baseline data reveal that, among adolescents, the average age of first use of cigarettes, alcohol, and marijuana was 12, 13, and 14 years, respectively.[4]

One of the Retention domain measures in the substance abuse prevention area is the percentage of youth seeing, reading, watching, or listening to a prevention message. Figure 5 shows that adolescents were more likely to see or hear prevention messages than to participate in prevention programs.

Data related to the Social Connectedness domain are provided in Table 1, which shows consistent improvements in family communication about the dangers of drug, tobacco, or alcohol use.

Under the Employment/Education domain are measures related to perception of workplace policy on alcohol or other drug use. Data from the 2004 NSDUH show that approximately 24 percent of adolescents aged 15 to 17 who were employed were willing to work for an employer who does employee drug tests on a random basis.[5]

Table 1. Number and Percent of Youths Who Talked with at Least One Parent in the Past Year about the Dangers of Drug, Tobacco, or Alcohol Use, by Age Category: 2003 and 2004

	2003		2004	
Age Category	Number	Percent	Number	Percent
Total	14,566	58.9*	15,063	60.3
12–13	5,043	60.6*	5,188	62.9
14–15	4,864*	59.4	5,194	60.4
16–17	4,659	56.6	4,681	57.4

* Difference between the 2003 estimate and the 2004 estimate is statistically significant at the 0.05 level. See notes at end.
Source: SAMHSA, OAS, (2005), 2004 National Survey on Drug Use and Health: Detailed tables [Tables 3.39A–B].

Crime and Criminal Justice domain measures concern alcohol-related car crashes and injuries and alcohol- and drug-related crime. While not directly applying to these measures, the 2004 NSDUH provides supplemental information—it found that only 4 percent of adolescents had driven under the influence of alcohol in the past year.[6]

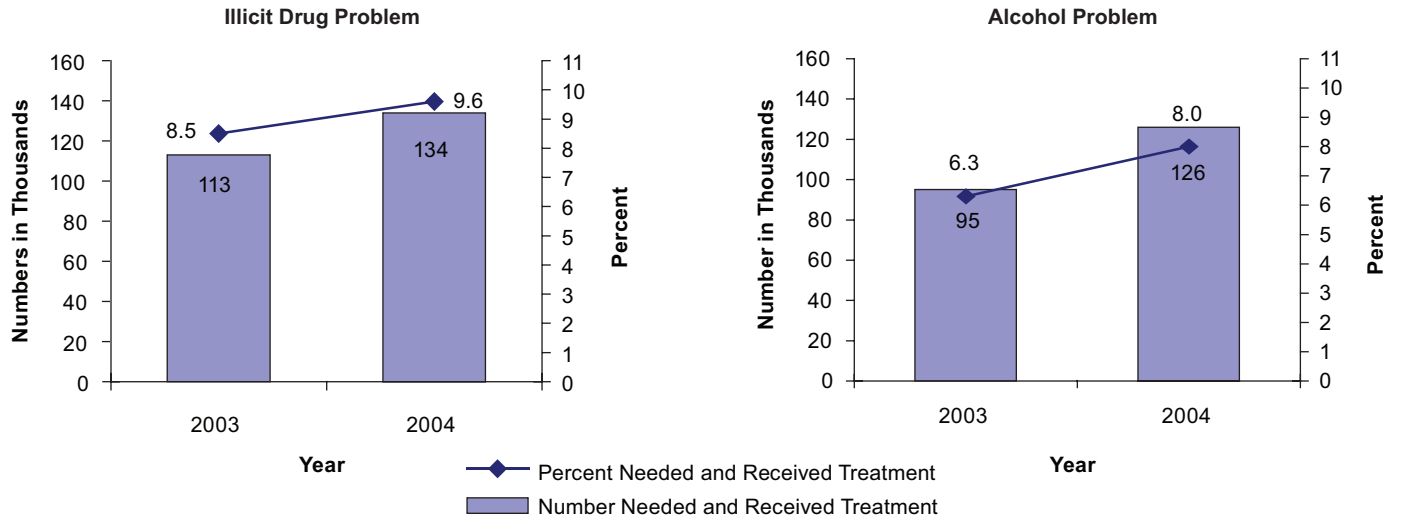
Thus, for Crime and Criminal Justice as well as the three remaining NOMs prevention domains (Access/Capacity, Cost Effectiveness, and Use of Evidence-Based Practices), information specific to the children, youth, and families population cannot be isolated from SAMHSA's national-level data sets and looked at independently from the broader population; thus, outcomes appropriate to the children, youth, and families population cannot be reported from SAMHSA's national-level data sets. However, SAMHSA's adolescent substance abuse prevention grant programs currently collect these data for use at the local provider level. In addition, some NOMs for substance abuse prevention will be obtained from data sets developed by other agencies such as the Departments of Transportation, Justice, and Education.

Substance Abuse Treatment NOMs for Children and Families

For substance abuse treatment, national-level data are available for children, youth, and families under the Access/Capacity and Retention domains. NSDUH[2] and N-SSATS[7] provide access/capacity data, while retention data are provided by the Treatment Episode Data Set (TEDS).[8]

The Access/Capacity domain measures are concerned with obtaining an unduplicated count of persons served and determining the penetration rate—numbers of clients served compared to those in need. N-SSATS, an annual census of facilities providing substance abuse treatment, provides data for the number of clients in treatment as well as information on types of services offered by these facilities. In 2004, data shows that 91,112 clients younger than age 18 were in treatment on March 31; of these, 87 percent were receiving outpatient care, 12 percent residential care, and 1 percent hospital inpatient care.[9] Most of these clients were adolescents, but this population also encompasses children younger than 12 years old in treatment, including infants exposed prenatally to substances. N-SSATS data also show that in 2004, half of all facilities accepted adolescents, and 31 percent offered programs or groups for

Figure 6. Number and Percent of Adolescents (Aged 12-17) Who Needed and Received Treatment at a Specialty Facility, by Type of Problem: 2003 and 2004



See notes at end.
Source: SAMHSA, OAS, (2005), 2004 National Survey on Drug Use and Health: Detailed tables [Table 5.74A and 5.86A].

adolescents. Among services offered by these facilities, some were directly related to the children and family area. These services included family counseling (76 percent of all facilities), domestic violence—family or partner violence services (32 percent), child care for clients' children (8 percent), and residential beds for clients' children (4 percent).

Penetration rate data come from NSDUH. In 2004, approximately 10 percent or 134,000 of all adolescents needing treatment for illicit drug use received it. NSDUH documents that roughly 1,262,000 adolescents overall needed but did not receive treatment for an illicit drug problem in 2004 (Figure 6). Similarly, approximately 8 percent or 126,000 of all adolescents needing treatment for an alcohol problem in 2004 received it. In that year, there were about 1,444,000 adolescents overall who needed but did not receive treatment for an alcohol problem.

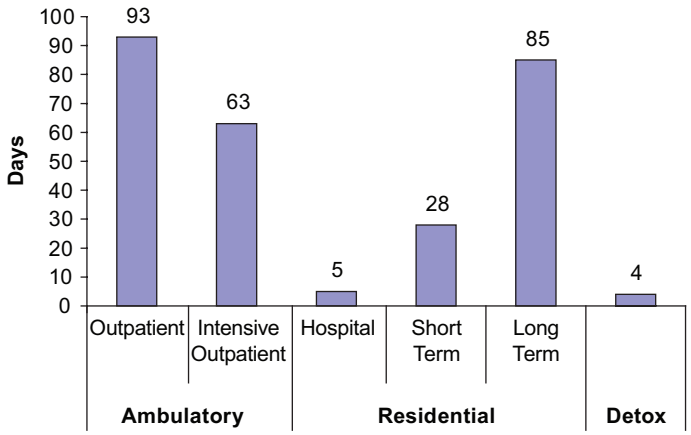
An available Retention domain measure is length of stay in treatment, which is reported by TEDS. In 2003, the median length of stay for discharges younger than 18 who completed their treatment varied by the type of service received: within ambulatory services, the median length of stay for outpatient care was 93 days and for intensive outpatient care 63 days; within residential services, median lengths of stay were 5 days for hospital care, 28 days for short-term care, and 85 days for long-term care; and the median length of stay for those completing detoxification services was 4 days (Figure 7).

Data on outcomes for four of the substance abuse treatment domains (Abstinence from Drug/Alcohol Use, Employment/Education, Crime and Criminal Justice, and Stability in Housing) will be available when the State Outcomes Measurement and Management System (SOMMS) data set is fully implemented in fiscal year (FY) 2008. For the remaining substance abuse treatment domains (Social Connectedness, Perception of Care, Cost Effectiveness, and Use of Evidence-Based Practices), information specific to the children, youth, and families population cannot be isolated from SAMHSA's national-level data sets and looked at independently from the broader population; thus, outcomes appropriate to the children, youth, and families population cannot be reported from SAMHSA's national-level data sets. However, SAMHSA's adolescent substance abuse treatment grant programs currently collect relevant data for use at the local provider level. For example, the Center for Substance Abuse Treatment (CSAT) program data indicate that the number of adolescents served in CSAT's Discretionary Services Program has grown sixfold from FY 2001 to FY 2005 (Figure 8).

Mental Health Services NOMs for Children and Families

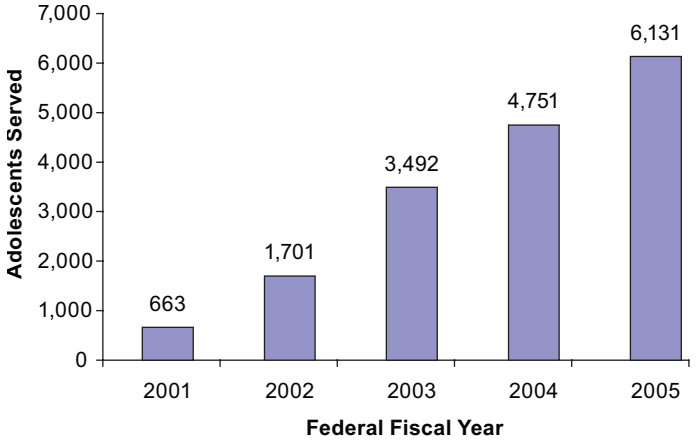
National-level mental health services data are available for 4 of the 10 domains (Stability in Housing, Access/Capacity, Reduced Utilization of Psychiatric Inpatient Beds, and Perception of Care). Data measuring Access/Capacity are from NSDUH.[2] In 2004, more than 5.6 million adolescents aged 12 to 17, over one fifth of this age group, received mental health treatment/counseling in the past year according to NSDUH data. Data measuring Stability of Housing, Reduced Utilization of Psychiatric Inpatient Beds, and Perception of Care are found in URS.[10] According to State mental health

Figure 7. Median Length of Stay for Discharges Younger than 18 Who Completed Substance Abuse Treatment, by Type of Service: 2003



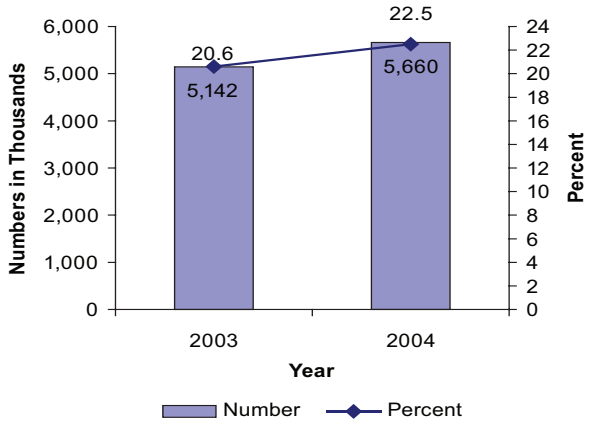
See notes at end.
Source: SAMHSA, OAS, 2003 TEDS [Data file—discharge data not released; for SAMHSA internal use only].

Figure 8. Number of Adolescents Served in CSAT's Discretionary Services Program: FY 2001–FY 2005



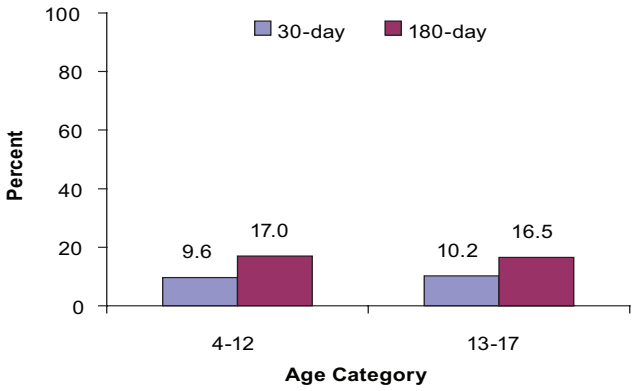
Source: SAMHSA, CSAT, 2005 Discretionary Services Program data.

Figure 9. Number and Percent of Adolescents (Aged 12–17) Who Received Mental Health Treatment/ Counseling in Past Year: 2003 and 2004*



* The difference between the 2003 estimate and the 2004 estimate is statistically significant at the 0.01 level. See notes at end.
Source: SAMHSA, OAS, (2005), 2004 National Survey on Drug Use and Health: Detailed tables [Tables 6.50A-B].

Figure 10. Rates of Readmission within 30 and 180 Days to Any Psychiatric Inpatient Bed in the State Mental Health Authority System, by Age Category: FY 2004

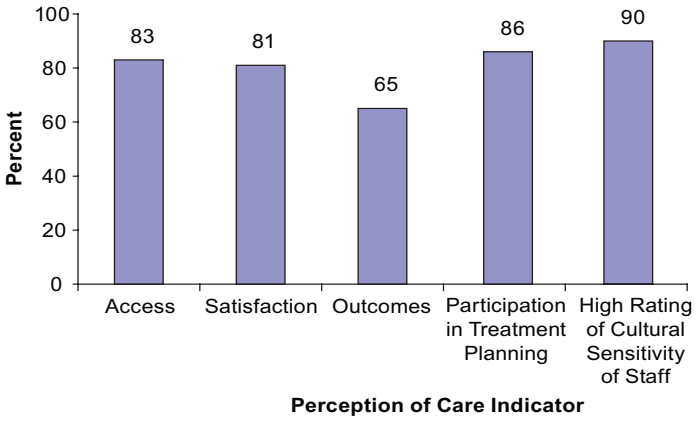


See notes at end.
Source: SAMHSA, CMHS, 2004 URS [Outcomes Domain Table 6].

agencies, a majority of mental health consumers younger than 18 years old—64 percent—were living in private residences.[11] State mental health agencies also reported that only about 17 percent of children overall were readmitted within 180 days of discharge, with lower rates for readmission within 30 days of discharge (Figure 10). States' Mental Health Service Consumer Surveys found that most family members of child or adolescent mental health consumers reported positively about treatment. Generally, high proportions of these consumers—80 to 90 percent—were satisfied when asked about five indicators of care (Figure 11).

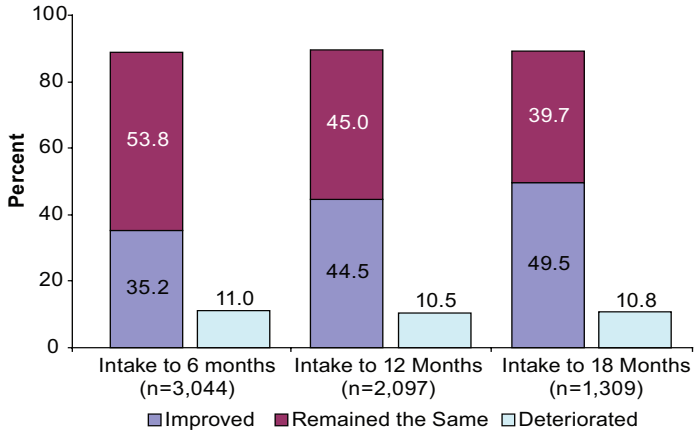
For the other six NOMs mental health services domains (Decreased Mental Illness Symptomatology, Employment/ Education, Crime and Criminal Justice, Social Connectedness, Cost Effectiveness, and Use of Evidence-Based Practices), information specific to the children, youth, and families population cannot be isolated from SAMHSA's national-level data sets and looked at independently from the broader population; thus, outcomes appropriate to the children, youth, and families population cannot be reported from SAMHSA's national-level data sets at this time. However, many mental health grant programs do collect

Figure 11. Percent of Mental Health Service Consumers Reporting Positively about Services/ Treatment for Children, by Perception of Care Indicator: FY 2004



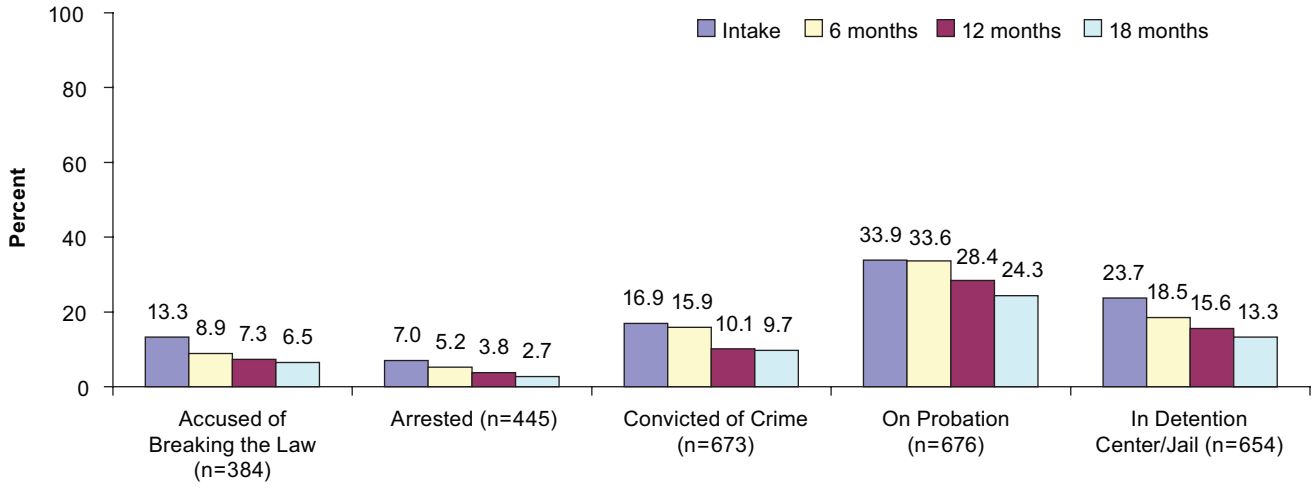
See notes at end.
Source: SAMHSA, CMHS, 2004 URS [Outcomes Domain Table 2].

Figure 12. Change in Children's Overall Behavioral and Emotional Problems, from Intake to 6 Months, Intake to 12 Months, and Intake to 18 Months: 2002–2003



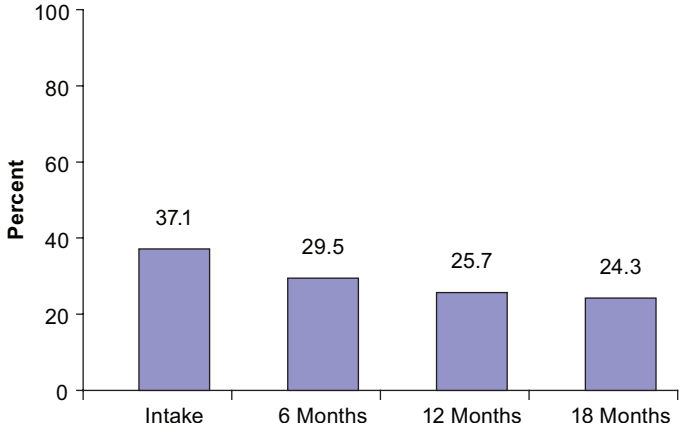
Source: SAMHSA, CMHS, (2003), *The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation findings—Annual Report to Congress, 2002–2003.*

Figure 13. Law Enforcement Contacts at Intake, 6 Months, 12 Months, and 18 Months: 2002–2003



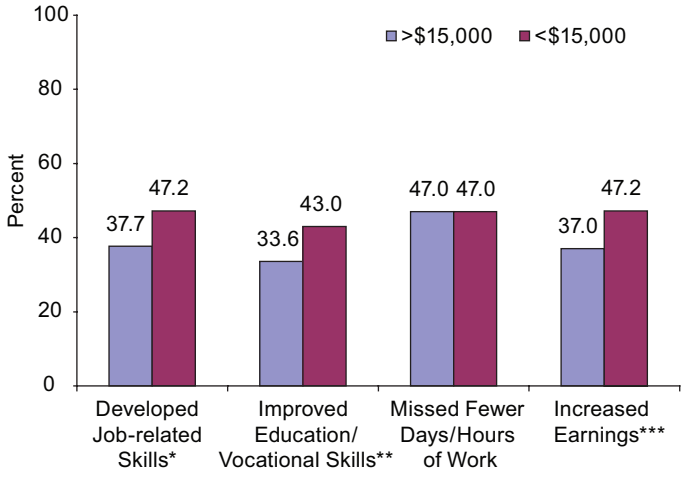
Source: SAMHSA, CMHS, (2003), *The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation findings—Annual Report to Congress, 2002–2003.*

Figure 14. Percent of Children Living in Multiple Settings at Intake, 6 Months, 12 Months, and 18 Months: 2002–2003



Number of children = 1,140.
Source: SAMHSA, CMHS, (2003), *The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation findings—Annual Report to Congress, 2002–2003.*

Figure 15. Percent of Improvement in Economic Outcomes of Caregivers from Intake to 18 Months After Entering Systems of Care for Caregivers with Incomes Above and Below $15,000 per Year: 2002–2003



Number of caregivers = 1,469.
* z = 3.38, p < .01.
** z = 3.42, p < .01.
*** z = 3.79, p < .01.
Source: SAMHSA, CMHS, (2003), T*he Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation findings—Annual Report to Congress, 2002–2003.*

specific evaluation data related to NOMs. For example, in the Comprehensive Community Mental Health for Children and Their Families Program, data indicate improvements in behavioral functioning, reduced contacts with police, increased stability in living situations, and improvements in parental employment status (Figures 12–15).[12] Further, the National Child Traumatic Stress Initiative is working to achieve higher levels of functioning for children and adolescents exposed to different types of trauma, improved school performance, and the introduction of evidence-based practices that are trauma-informed.

Table Note:

Table 1: Respondents with unknown data were excluded (NSDUH Table 3.39A–B).

Figure Notes:

Figure 1: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

Figure 2: Respondents with unknown data were excluded (NSDUH Table 3.1B).

Figure 3: Respondents with unknown data were excluded (NSDUH Tables 3.30B, 3.31B, 3.32B, 3.33B).

Figure 5: The substance prevention program refers to "a Drug, Tobacco, or Alcohol Prevention Program Outside School in the Past Year" (Table 3.36B); the program dealing with substance use refers to "a Program in the Past Year for Dealing with Drug or Alcohol Use" (NSDUH Table 3.37B); the exposure to prevention messages refers to "Saw or Heard Drug or Alcohol Prevention Messages from Sources" outside of or at school in the past year (NSDUH Tables 3.40B and 3.41B). Respondents with unknown data were excluded.

Figure 6: Respondents were classified as needing treatment for an illicit drug problem if they met at least one of three criteria during the past year: (1) dependent on illicit drugs; (2) abuse of illicit drugs; or (3) received treatment for an illicit drug problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers) (NSDUH Table 5.74A). For the definition of Illicit Drugs, see note for Figure 1. Respondents were classified as needing treatment for an alcohol problem if they met at least one of three criteria during the past year: (1) dependent on alcohol; (2) abuse of alcohol; or (3) received treatment for an alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers) (NSDUH Table 5.86A).

Figure 7: These are preliminary estimates based on data from the 26 States or jurisdictions that had linked discharge to admission records for 2003. This age group (younger than 18) included newborns with a substance dependency problem. The service categories exclude records where methadone treatment was planned (TEDS data file).

Figure 9: Mental Health Treatment/Counseling for youths is defined as having received treatment or counseling from any of 10 specific sources (e.g., private therapist, school counselor, special school program) for emotional or behavioral problems NOT caused by drug or alcohol use. Youths who answered none of the source of treatment questions with a "yes" and answered "no" four or fewer times were excluded from this analysis (NSDUH Tables 6.50A and 6.50B).

The 10 categories are defined in NSDUH Table 6.54A. Note that respondents could indicate multiple sources; thus, these response categories are not mutually exclusive: 1) private therapist, psychologist, psychiatrist, social worker, or counselor; 2) school counselor, school psychologist, or having regular meetings with a teacher; 3) mental health clinic or center; 4) in-home therapist, counselor, or family preservation worker; 5) pediatrician or other family doctor; 6) overnight or longer stay in any type of hospital; 7) special education services while in a regular classroom or in a special classroom or placement in a special program or special school; 8) partial day hospital or day treatment program; 9) overnight or longer stay in a residential treatment center; and 10) overnight or longer stay in foster care or in a therapeutic foster care home. (Respondents who did not report their school enrollment status or who reported not being enrolled in school in the past 12 months were not asked about receipt of mental health treatment/counseling from sources 2 and 7.)

Figure 10: Data on the 30-day readmission counts/rates for 4- to 12-year-olds were reported by 7 States or jurisdictions and for the 12- to 17-year-olds by 10 States or jurisdictions. Data on the 180-day readmission counts/rates reported by 6 and 9 States or jurisdictions, respectively, for the two age groups (URS Outcomes Domain Table 6).

Figure 11: Consumer Survey results are reported in URS Outcomes Domain Table 2. The five indicators relevant to children and families were phrased in the Customer Survey, respectively, as following: Reporting Positively about Access (40 States reported); Reporting Positively about Satisfaction for Children (41 States reported); Reporting Positively about Outcomes (40 States reported); Family Members Reporting on Participating in Treatment Planning (41 states reported); and Family Members Reporting High Cultural Sensitivity of Staff (38 States reported).

References:

1. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2005). *Results from the 2004 National Survey on Drug Use and Health: National findings* (NSDUH Series H-28, DHHS Publication No. SMA 05-4062—Figures 2.4, 5.3). Rockville, MD. Retrieved February 12, 2006, from http://www.oas.samhsa.gov/nsduh/2k4nsduh/2k4Results/2k4Results.htm#toc

2. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2005). *2004 National Survey on Drug Use and Health: Detailed tables* (Tables 3.1B, 3.30B, 3.36B, 3.37B, 3.39A, 3.39B, 3.40B, 3.41B, 3.66B, 5.74A, 5.86A, 6.50A-B, 7.91B). Retrieved January 17, 2006, from http://www.oas.samhsa.gov/NSDUH/2k4nsduh/2k4tabs/toc.htm#TopOfPage

3. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *2004 National Survey on Drug Use and Health* [Data file].

4. Data were not released in the 2004 NSDUH report. The estimates for the age of first use of cigarettes, alcohol, and marijuana were generated from, respectively, CIGTRY, ALCTRY, MJAGE, with respective missing cases counted 12,781, 10,441, and 14,703.

5. Data were not released in the 2004 NSDUH report. For the variable on the willingness to work for an employer that does drug test on a random basis (WRKRAND), there were 15,157 cases that were defined to be legitimate skips because: (1) they were younger than 15 years old and/or they were not employed.

6. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2005). *2004 National Survey on Drug Use and Health: Detailed tables* (Table 7.91B). Retrieved March 2, 2006, from http://www.oas.samhsa.gov/NSDUH/2k4nsduh/2k4tabs/toc.htm#TopOfPage

7. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2005). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2004. Data on substance abuse treatment facilities* (DASIS Series: S-28, DHHS Publication No. SMA 05-4112—Tables 2.5, 3.5, 4.8B, 4.10B). Rockville, MD. Retrieved February 14, 2006, from http://wwwdasis.samhsa.gov/04nssats/index.htm

8. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *2003 Treatment Episode Data Set* [file of data received through September 14, 2005—discharge data not released; for SAMHSA internal use only].

9. N-SSATS collects capacity information according to the type of care offered within a facility. in 2004, facilities were asked for the number of clients in non-hospital residential and hospital inpatient care as of the census date—march 31; however, facilities offering outpatient care were asked about the number of active clients—individuals who were seen at the facility for a substance abuse treatment or detox service at least once during the census month, and who were still enrolled in substance abuse treatment services as of the census date.

10. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2005). *2004 CMHS Uniform Reporting System output tables* (Outcomes Domain Tables 2 and 6, Appropriateness Domain Table 5). Retrieved January 13, 2006, from http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/URS2004.asp

11. Data on the percentage of children younger than 18 years old living in private residences was provided by 34 States or jurisdictions (URS Appropriateness Domain Table 5). Retrieved January 13, 2006, from http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/URS2004.asp

12. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2003). *The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation findings—Annual Report to Congress, 2002–2003*. Atlanta, GA: ORC Macro.